OMB Number: 2900-0080 Estimated Burden: 2 minutes Expiration Date: 10/30/2004

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AUTHORIZATION AND INVOICE FOR MEDICAL AND HOSPITAL SERVICES

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1A. DATE OF ISSUE	1B. ISSUIN	IG OFFICE	FFICE 1C. DATE OF ISSUE (Month, day, year)								
							1D. VETERAN'S NAME (Fi	st, mid	dle initial, las	t)	
2. NAME OF F	PHYSICIAN (OR FACILITY					3. VETERAN'S CLAIM NUI	/IBER	4. SOCIA	AL SECU	JRITY NUMBER
							C-				
							5. <i>A</i>	UTHOF	RIZATION VA	LID	
							FROM		ТО		
					PART I - SFI	 RVICES AUTH	IORIZED				
				OR THE P	ERIOD INDICATE						7. FEE
(See special	l provisions (on the back of th	is form.)								\$
											•
8. FEE SCHED	ULE OR CO	NTRACT		9. AL	JTHORITY	9A.			10. ESTI	MATED	AMOUNT
11. FISCAL SYMBOLS 360160.001						12. AUTHORIZE	D BY (Name and Title)				
30											
12 DA	TE(C)	14 DESCRIP	TION O	E SEDVIC		T II - INVOICI		d onto	<u> </u>		15. FEE
13. DATE(S) OF SERVICE 14. DESCRIPTION OF SERVICE (If services furnithe remark "As Authorized Above" in this column							e, itemize services.)	i, ente	1		CLAIMED
MONTH DAY	′ YEAR				S	ERVICE FURNISH	ED				AMOUNT
											\$
											•
15A. SOCIAL OR EMPLOYER			Indivi	dual or o	rganization furn	ishing service,	16. BILLING DATE		47.7	ОТ 4.1	
			enter (Cont	billing da inue billir	ate and amounting on back if ne	claimed. cessary.)			CLA	OTAL	\$
						FOR VA USE	ONLY				
		ADMINISTR	ATIVE C	ERTIFICA		TON VA COL	T T	AL	DIT BLOCK		
Payment	of this will r	not cause navee t	o excee	d maximur	n amount allowed	L Services have	AMOUNT DUE		DATE	VOU	CHER AUDITOR
					pt as stated below		\$				
							REMARKS				
SIGNATURE A	ND TITLE					DATE					
ION DAT NO		TC % CC	-			CCOUNTING	BLOCK				DATE/INITIAL C
ION PAT NO		TC & SC			LIQ	AMT	1ST SA		\$		DATE/INITIALS
				CPF			2ND SA		\$		1
ZND SA						1		•		I	

VA FORM MAY 2001 (R)

			PART II - INVOICE	(Continued)		
13 OF	B. DATE	(S) CE	14. DESCRIPTION C	OF SERVICE		15. FEE CLAIMED
MONTH	DAY	YEAR				AMOUNT
MONTH	DAY	YEAR				\$
1	*	Pleas	se enter total shown in 17A. Enter this in 17on front of form also.	16. BILLING DATE	17A. TOTAL CLAIMED	\$

- *ACCEPTANCE OF THIS AUTHORIZATION AND PROVIDING OF SUCH TREATMENT OR SERVICES SUBJECTS YOU, THE PROVIDER OF CAR, TO THE PROVISIONS OF PUBLIC LAW 93-579, THE PRIVACY ACT OF 1974, TO THE EXTENT OF THE RECORDS PERTAINING THE VA AUTHORIZED TREATMENT OR SERVICES OF THIS VETERAN.
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All questions relating to this authorization should be referred to the issuing VA Facility.

VA FORM MAY 2001 (R) 10-7078 REVERSE ORIGINAL

🔀 Department of Veterans Affairs

AUTHORIZATION AND INVOICE FOR MEDICAL AND HOSPITAL SERVICES

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							1D. VETERAN'S NAME (Firs	st, mide	dle initial, las	t)	
2. NAME OF I	PHYSICIAN (OR FACILITY					3. VETERAN'S CLAIM NUM	BER	4. SOCIA	AL SECU	IRITY NUMBER
						•	5. AL	THOR	ZATION VA	LID	
						•	FROM		ТО		
					DARTI CE	DVICEC ALITI	IODIZED				
						RVICES AUTH D IN ITEM 5 ABO					7. FEE
(See specia	al provisions (on the back of th	is form.)								\$
8. FEE SCHEE	DULE OR COI	NTRACT		9. AU	JTHORITY	9A.			10. ESTIN	MATED .	AMOUNT
11. FISCAL S 36	YMBOLS				0160.001	12. AUTHORIZE	D BY (Name and Title)				
					PAR	T II - INVOICE					
13. DA		14. DESCRI	PTION	OF SERVI	CE (If services	furnished are id	entical to those authorize se, itemize services.)	d, ent	er		15. FEE
OF SER	_	the remark	AS Aut	nonzeu A		ERVICE FURNISH	-				AMOUNT
						LITTICE I OTTIVION					\$
15A. SOCIAL OR EMPLOYE			Indivi enter	dual or or	ganization furni te and amount g on back if ne	ishing service,	16. BILLING DATE		17. T	OTAL IMED	
			(Cont	inue billin	g on back if ne	cessary.)			CLA	IMED	\$
						FOR VA USE	ONLY				
		ADMINISTR	ATIVE (CERTIFICA	TION			AU	DIT BLOCK		
					n amount allowed pt as stated belov	I. Services have	AMOUNT DUE	+	DATE	VOU	CHER AUDITOR
			,				\$				
							REMARKS				
SIGNATURE A	AND TITLE					DATE					
					PART IV - A	CCOUNTING	BLOCK				
ION PAT NO		TC & SC			LIQ	AMT	1ST SA		\$		DATE/INITIALS
				CPF			2ND SA		\$		

VA FORM MAY 2001 (R)

			PART II - INVOICE	(Continued)		
13 OF	B. DATE(SERVIO	S) CE	14. DESCRIPTION C	OF SERVICE		15. FEE CLAIMED
монтн	DAY	YEAR				AMOUNT
IN ON I F	DAT	TEAR				\$
•	→	Pleas total	e enter total shown in 17A. Enter this in 17on front of form also.	16. BILLING DATE	17A. TOTAL CLAIMED	\$

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VA FORM REVERSE COPY 2
MAY 2001 (R) 10-7078

Department of Veterans Affairs

AUTHORIZATION AND INVOICE FOR MEDICAL AND HOSPITAL SERVICES

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						-	1D. VETERA	AN'S NAME (First	, mido	dle initial, las	t)	
2. NAME OF P	HYSICIAN (OR FACILITY					3. VETERA	N'S CLAIM NUMB	ER	4. SOCIA	AL SECU	RITY NUMBER
							C-					
								5. AUT	HORI	ZATION VAI	LID	
							FROM			ТО		
					PART I - SEI	RVICES AUTH	IORIZED					
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(Oce special	provisions	on the back of th	15 101111./									\$
8. FEE SCHED	ULE OR COI	NTRACT		9. AU	JTHORITY	9A.				10. ESTIN	MATED A	AMOUNT
11 FISCAL SV	/MPOLS				12. AUTHORIZE	D BV (Name	and Title)					
11. FISCAL SYMBOLS 3601						12. AUTHORIZE	DDT (IName	and mie)				
					PAR	T II - INVOICE						
13. DAT OF SER	TE(S)	14. DESCRI	PTION (OF SERVI	CE (If services	furnished are id	entical to t	hose authorized	l, ent	er		15. FEE CLAIMED
MONTH DAY	- 	the remark	As Aut	IOTIZEU A		ERVICE FURNISH		361 VICE3./				AMOUNT
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15A. SOCIAL			Indivi	dual or or	ganization furn	ishina service	16. BIL	LING DATE				
OR EMPLOYER	K ID NOMBE	K	enter	billing da	ganization furn te and amount g on back if ne	claimed.				17. T CI A	OTAL IMED	\$
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VA FORM MAY 2001 (R)

			PART II - IN'	VOICE (Continued)		
13 OI	B. DATE SERVI	(S) CE	14. DESCRII	PTION OF SERVICE		15. FEE CLAIMED
монтн	DAY	YEAR				AMOUNT
						\$
1	*	Pleas	e enter total shown in 17A. Enter the in 17A. Enter the in 17on front of form also.	his 16. BILLING DATE	17A. TOTAL CLAIMED	\$

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VA FORM MAY 2001 (R) 10-7078 REVERSE COPY 3

Department of Veterans Affairs

AUTHORIZATION AND INVOICE FOR MEDICAL AND HOSPITAL SERVICES

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2. NAME OF P	HYSICIAN (OR FACILITY					3. VETERA	N'S CLAIM NUMB	ER	4. SOCIA	AL SECU	RITY NUMBER
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(Oce special	provisions	on the back of th	15 101111./									\$
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11 FISCAL SV	/MPOLS				12. AUTHORIZE	D BV (Name	and Title)					
11. FISCAL SYMBOLS 3601						12. AUTHORIZE	DDT (IName	and mie)				
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OR EMPLOYER	K ID NOMBE	K	enter	billing da	ganization furn te and amount g on back if ne	claimed.				17. T CI A	OTAL IMED	\$
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Payment of this will not cause payee to exceed maximum amour been furnished as authorized or medically approved except as sta							\$	100111 202		57.12	****	OHEN NOBITON
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							REMAR	K5				
SIGNATURE A	ND TITLE					DATE						
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ION PAT NO		TC & SC			LIQ	ACCOUNTING AMT	BLUCK					DATE/INITIALS
							1ST SA	A		\$		/
	CPF						2ND SA	2ND SA \$				

VA FORM MAY 2001 (R)

	PART II - INVOICE (Continued)										
13 OF	13. DATE(S) OF SERVICE 14. DESCRIPT		OF SERVICE		15. FEE CLAIMED						
MONTH	DAY	YEAR				AMOUNT					
MONTH	DAY	YEAR				\$					
	₩	Pleas this t	e enter total shown in 17A. Enter otal in 17 on front of form also.	16. BILLING DATE	17A. TOTAL CLAIMED	\$					

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VA FORM MAY 2001 (R) 10-7078 REVERSE COPY 4

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						•	5. AL	THOR	ZATION VA	LID	
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						RVICES AUTH D IN ITEM 5 ABO					7. FEE
(See specia	al provisions (on the back of th	is form.)								\$
8. FEE SCHEE	OULE OR COI	NTRACT		9. AU	JTHORITY	9A.			10. ESTIN	MATED .	AMOUNT
11. FISCAL S 36	YMBOLS				0160.001	12. AUTHORIZE	D BY (Name and Title)				
					PAR	T II - INVOICE					
13. DA		14. DESCRI	PTION	OF SERVI	CE (If services	furnished are id	entical to those authorize se, itemize services.)	d, ent	er		15. FEE
OF SER	_	the remark	AS Aut	nonzeu A		ERVICE FURNISH	-				AMOUNT
						LITTICE I OTTIVION					\$
15A. SOCIAL OR EMPLOYE			Indivi enter	dual or or	ganization furni te and amount g on back if ne	ishing service,	16. BILLING DATE		17. T	OTAL IMED	
			(Cont	inue billin	g on back if ne	cessary.)			CLA	IMED	\$
						FOR VA USE	ONLY				
		ADMINISTR	ATIVE (CERTIFICA	TION			AU	DIT BLOCK		
					n amount allowed pt as stated belov	I. Services have	AMOUNT DUE	+	DATE	VOU	CHER AUDITOR
			,				\$				
							REMARKS				
SIGNATURE A	AND TITLE					DATE					
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ION PAT NO		TC & SC			LIQ	AMT	1ST SA		\$		DATE/INITIALS
				CPF			2ND SA		\$		

VA FORM MAY 2001 (R)

			PART II - INVOICE	(Continued)		
13 OF	B. DATE	(S) CE	14. DESCRIPTION C	OF SERVICE		15. FEE CLAIMED
MONTH	DAY	YEAR				AMOUNT
MONTH	DAY	YEAR				\$
3	+	Pleas	se enter total shown in 17A. Enter this in 17on front of form also.	16. BILLING DATE	17A. TOTAL CLAIMED	\$

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